United Nations ST/IC/2004/57

Secretariat

9 December 2004

# Information circular*

To: Members of the staff at offices away from Headquarters

From: The Controller

Subject: **Vanbreda medical, hospital and dental insurance programme for staff members away from Headquarters**

## I. Renewal provisions for 2005

1. Premium change: new premium and contribution rates come into effect on 1 January 2005 (see chart in para. 11).

2. Programme changes beginning 1 January 2005

(a) Participants are no longer restricted in seeking a second opinion for any particular procedure, as was true in prior years. Participants may now obtain a second opinion for any planned surgery, and the programme will reimburse all such second opinions at the rate of 100 per cent of the reasonable and customary charge. A third opinion, if necessary, is also reimbursed at the rate of 100 per cent. The programme does not assess a financial penalty or reduction in the reimbursement for the surgeon's charge if a second opinion is not obtained.

(b) The conversion privilege is offered for the first time to dependent children on their own behalf, who lose their eligibility for insurance on account of attaining the age of 25 years. Details are found in section V, paragraphs 38-40.

## II. Other important information for 2005

**Vanbreda eligibility applies for residents of all nations except of the United States**

3. The Vanbreda programme covers staff members and former staff members who reside in all parts of the world, **except** the United States of America (see also para. 15). Staff members, former staff members and their dependants **who reside in the United States of America are not eligible for Vanbreda coverage**. The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States, who is required to have the health insurance coverage mandated by the educational institution. In this case, the student's health insurance plan will be primary and the Vanbreda coverage will be secondary.

* Expiration date of the present information circular: 31 December 2005.

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**Annual enrolment campaign in 2005**

4. Staff members are reminded that the 2005 annual enrolment campaign will be the only general opportunity in 2005 to enrol themselves and eligible family members in the Vanbreda plan. The annual enrolment campaign for the Vanbreda plan for staff members assigned to duty stations around the world is scheduled to be held from 6 to 10 June 2005.

**Vanbreda dedicated web site/Vanbreda identification cards/official designation**

5. Vanbreda has created a dedicated section on its web site, www.vanbreda-international.be in respect of the United Nations worldwide Vanbreda plan. This section can be accessed by logging on with a personal reference number indicated on the Vanbreda membership card. The web site provides details regarding: (i) benefits; (ii) how to arrange for direct billing; (iii) how to submit a claim; (iv) provision for the downloading of forms, e.g., claim form; (v) contact nformation at Vanbreda; and (vi) a provider list enabling a participant to select medical providers based upon location and medical specialization.

6. The Vanbreda identification card mailed to all participants enables a hospital or clinic to contact Vanbreda in order to set up a direct billing arrangement in respect of hospitalization or high-cost out-patient treatment. Participants who do not have an identification card should contact Vanbreda (please refer to para. 43).

**General administration**

7. The existing rules and terms governing eligibility and enrolment for the Vanbreda plan are summarized in paragraphs 13 to 37.

## III. 2005 premiums and benefits

8. The premiums are based solely on the claims incurred by the participants in the United Nations programme, plus the appropriate allowance for the cost of administration. Because the claim costs are incurred in all parts of the world they reflect varying price levels. Accordingly, three premium rate groups have been established in order to enable the determination of premiums that are broadly commensurate with the expected overall level of claims for the locations included within each rate group.

9. The financial performance of the programme for the past policy period reflected higher medical inflation and utilization, which require an increase in the premiums. The decline of the United States dollar relative to other currencies in 2003-2004 has had an equally important effect. As a result of those two factors, premiums must increase by 13.67 per cent for all participants worldwide, with effect from 1 January 2005. The differentials between Chile and Mexico, and Western Europe, as compared to the rest of the world, will be maintained for 2005. These differentials are supported by the actual experience of the programme.

10. The premium contributions of participants in the Vanbreda scheme are determined as a percentage of the respective medical net salaries[1] by applying the

[1] Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the total premiums.

rates set out in paragraph 11 below. These staff member contribution percentages take into account the General Assembly requirement for an overall 50:50 cost-sharing relationship between the Organization and participants in the plan. This is consistent with the methodology used in calculating staff contributions towards other United Nations insurance programmes.

11. The schedule of premiums that will become effective on 1 January 2005, as well as the related staff contribution rates, are set out in the table below.

| | *Monthly premium (United States dollars)* | | *Percentage of medical net salary* | |
|---|---|---|---|---|
| | *Effective 1 January* | | *Effective 1 January* | |
| *Type of coverage* | *2004* | *2005* | *2004* | *2005* |
| **A. All duty stations (other than Chile, Mexico and Western Europe)** | | | | |
| Staff member only | 98.00 | 111.00 | 1.34 | 1.52 |
| Staff member and one family member | 209.00 | 238.00 | 2.10 | 2.39 |
| Staff member and two or more eligible family members | 345.00 | 392.00 | 3.36 | 3.82 |
| **B. Chile and Mexico** | | | | |
| Staff member only | 160.00 | 182.00 | 2.32 | 2.35 |
| Staff member and one family member | 337.00 | 383.00 | 3.78 | 3.83 |
| Staff member and two or more eligible family members | 557.00 | 633.00 | 5.99 | 6.07 |
| **C. Western Europe** | | | | |
| Staff member only | 160.00 | 182.00 | 2.32 | 2.35 |
| Staff member and one family member | 337.00 | 383.00 | 3.78 | 3.83 |
| Staff member and two or more eligible family members | 557.00 | 633.00 | 5.99 | 6.07 |

**Western Europe includes the following countries:** Andorra, Austria, Belgium, Crete, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey (European portion), United Kingdom.

**Hospital room rate maxima**

12. A detailed summary of the Vanbreda benefits is included as annex I. That paragraph draws attention specifically to the daily room rate maximum for hospital accommodation reimbursable under the programme for 2005:

(a) **Europe and North America.** The maximum reimbursement per day for hospital accommodation (room and board) in Europe and North America is $600. (See also annex II for more information.) Semi-private room accommodation is the normal standard in Europe and North America. Only under the following conditions, subject to the provision of documentation satisfactory to the insurer, will private-room care be considered for reimbursement in full, up to the $600 daily limit:

(i) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation; that is, it has no standard of accommodation other than private rooms and general wards;

Europe and North America are defined for this purpose as the continent of Europe, including Malta, Cyprus and Turkey (European portion), and Canada and the United States of America.

(b) **Israel.** The daily room rate limit applicable in Israel is $700. This reimbursement ceiling conforms to the nationally uniform semi-private hospital accommodation rate in that country;

(c) **Rest of world.** The daily reimbursement limit is $330, applicable to all locations other than Europe, North America and Israel.

## IV. Eligibility and enrolment rules

### General rules

13. The annual enrolment campaign will be the only general opportunity in 2005 for staff members under the 100 Series of the Staff Rules to enrol themselves and eligible family members in the Vanbreda plan. The annual enrolment campaign for the Vanbreda plan for staff members assigned to duty stations around the world is tentatively scheduled to be held from 6 to 10 June 2005. Please also refer to paragraphs 21-23.

14. Except for staff members whose duty station is within the United States and locally recruited staff members at duty stations where the Medical Insurance Plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 Series of the Staff Rules or one month or longer under the 200 Series of the Staff Rules may enrol themselves and eligible family members in the Vanbreda plan. Staff members holding appointments of limited duration of three months or longer under the 300 Series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in the Vanbreda plan.

15. Enrolment in the Vanbreda plan at the time of initial appointment must be accomplished within 31 days of the date of entry on duty. **Staff members are not eligible for coverage under the Vanbreda plan if they or any of their covered dependants reside in the United States.** For enrolment purposes, applicants will be required to present (a) a Vanbreda application form, and (b) proof of eligibility in

the form of a personnel action (PA) document provided by their respective personnel or administrative officers attesting to the current contractual status. The enrolment of eligible family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the personnel action form.

**Eligible family members for insurance purposes**

16. An "eligible family member" is a recognized spouse and one or more eligible children. The recognized spouse is always eligible. A child must be the natural-born or legally-adopted child of the staff member. Children are eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married and not employed full time. Disabled children may be eligible for continued coverage after the age of 25, subject to a disability determination by the United Nations Medical Services Department.

**Change in residence or duty station**

17. Headquarters New York staff members have the option to enrol in the Vanbreda plan while on assignment to a field office or mission outside the United States. Upon return to a United States-based assignment, these staff members must reapply for a United States-based United Nations health insurance programme.

18. Staff members away from Headquarters New York who are assigned to a post in the United States must enrol in a United States-based United Nations health insurance programme. When residence in the United States ends, these staff members may reapply for coverage in the Vanbreda programme.

19. A change in coverage following a change in residence or return from mission assignment will become effective the first day of the month after arrival at the new place of residence or duty station.

**20. Please note that there are circumstances in which insurance cannot be automatically continued; for example, when the payrolling office changes. For this reason, whenever your country of residence or duty station changes, it is important that you confirm with your personnel or administrative office whether you need to submit an application to continue (or change) your insurance.**

**Enrolment at times other than upon entry on duty**

21. Staff members appointed under the 100 Series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty have an opportunity once each year to do so, during the annual enrolment period (see para. 13). The effective date of insurance coverage for which application is made during the annual enrolment period is the first day of July.

22. Staff members appointed under the 200 Series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance scheme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance scheme provided by the United Nations, may enrol their spouses and dependent children in the scheme. Project personnel who

have not enrolled their spouses and eligible dependent children in the Vanbreda plan at the time of initial appointment have an annual opportunity to do so. In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty, and insurance coverage for added dependants will be effective as of that date.

23. Staff members holding appointments of limited duration under the 300 Series of the Staff Rules who have not enrolled themselves in the Vanbreda plan at the time of initial appointment because they maintain their own coverage have an annual opportunity to enrol in a United Nations programme. Their annual enrolment opportunity occurs on the anniversary of their entry on duty.

24. At times other than the annual enrolment periods referred to in paragraphs 21 to 23 above, Series 100 and 200 staff members and their eligible family members may be enrolled in the Vanbreda plan *only* if at least one of the following events occurs *and* application for enrolment is made within 31 days of the event:

(a) Upon transfer from one duty station to another;

(b) Upon return from special leave without pay (see para. 30 below);

(c) Upon assignment to a mission under certain conditions (see para. 31 below);

(d) Upon marriage, birth or legal adoption of a child, for coverage of the related family member.

25. Loss of coverage under a spouse's health insurance plan by virtue of the spouse's loss of employment is a qualifying event for the purpose of enrolment in a United Nations plan. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

26. Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

27. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraphs 24-26 above, and/or not received within 31 days of the event giving rise to eligibility, will not be receivable.

**Commencement and termination dates of health insurance coverage**

28. New coverage for a staff member newly enrolled in the Vanbreda plan commences on the first day of a qualifying contract. If the first day of a qualifying contract occurs later than the first day of the month, coverage commences on that day or the participant may opt for coverage to commence on the first day of the following month. In no event can coverage commence prior to the first day of the qualifying contract. Health insurance coverage terminates at the end of the month in which the qualifying contract ends. Therefore, if a contract terminates before the last day of a month, coverage will remain in place until the end of that month. Treatment for illness which occurs within the period of the contract will be covered

by the programme. Treatment for illness or a condition that occur after the contract period are not covered.

**Staff transferred to another duty station**

29. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment must be in one of the health insurance plans offered at Headquarters. **Staff members are reminded that if a duty station transfer involves a change from one payroll system to another, the staff member must, upon arrival at the new duty station, confirm through their administrative or personnel office that their insurance coverage is recorded in the new payroll system. Otherwise, the staff member's insurance will expire at the end of the month in which the deduction of monthly premium contributions ceases.**

**Staff on special leave without pay**

30. Staff members who are granted special leave without pay are reminded that they may retain health insurance coverage during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) **Insurance coverage maintained during special leave without pay.** If the staff member decides to retain coverage during the period of special leave without pay, the Insurance office (if payrolled at Headquarters) or the relevant administrative office (if payrolled elsewhere) *must* be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (both the staff member's contribution and the Organization's share, since no subsidy is payable during such leave);

(b) **Insurance discontinued while on special leave without pay.** Should a staff member decide not to retain insurance coverage while on special leave without pay, no action is required upon commencement of the special leave. However, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

**Staff members on mission assignment**

31. Staff members going on mission assignment are entitled to a special health insurance enrolment opportunity.

(a) Staff members who at present are *not* enrolled in the Vanbreda plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in the plan in these circumstances must be completed *prior* to the departure of the staff member on mission assignment;

(b) Staff members who elect to enrol in the Vanbreda plan in the circumstances set out in subparagraph (a) above forgo the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Vanbreda plan or change their present coverage, as provided above, must present evidence to the Insurance Service or to their administrative office, as the case may be, of the mission assignment and its duration.

**Staff member married to another staff member**

32. Staff members are reminded that in the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member. It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service. The spouse in active service must complete the appropriate insurance application form to ensure continuity of coverage for both self and spouse.

**Staff members with dependants residing in the United States**

33. Staff members are reminded that the Vanbreda plan is designed to provide hospital, medical and dental coverage for participants residing outside the United States. Therefore, staff members residing outside the United States but with covered eligible dependants residing in the United States, other than school or university students with health insurance coverage mandated by the educational institution, must enrol instead in a Headquarters health insurance programme. Please note that the Headquarters dental programme is separate from medical, and a separate application must be made for dental, if dental insurance is desired.

**Cessation of family members' coverage**

34. The Insurance office at Headquarters or the relevant administrative office should be notified immediately in writing of changes in the staff member's family which result in a family member ceasing to be eligible (for example, a spouse upon divorce, a child reaching the age of 25 years, marrying or taking up full-time employment). Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (for example, from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution that may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive contribution adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Service or administrative office.

**After-service health insurance**

35. Eligibility rules for participation in the United Nations after-service health insurance programme, together with related administrative procedures, are set out in administrative instruction ST/AI/394, dated 19 May 1994. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a United Nations health insurance scheme at the time of separation from service. A minimum of five years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over at the date of separation and must have elected to receive a monthly retirement benefit or deferred monthly retirement benefit from the United Nations Joint Staff Pension Fund. It should also be noted that only those family members enrolled with the staff member at the time of separation are eligible for coverage under the after-service health insurance programme. Please take note that service under a 300-Series appointment of limited duration does **not** count towards eligibility for after-service health insurance.

36. Former staff members who reside in the United States are reminded that they are NOT eligible for participation in the Vanbreda plan and that they must switch to a Headquarters plan within 31 days of taking up residence in the United States.

**Retirees who return to active service**

37. Retirees who return to active service with the Organization may temporarily be ineligible for health insurance coverage under the United Nations after-service health insurance programme. This can occur if the monthly pension benefit is suspended because of resumed status as active staff. In that case eligibility to participate in the after-service health insurance programme is suspended while pension benefits are suspended, because eligibility for after-service health insurance is contingent upon continued receipt of a monthly UNJSPF benefit. When that occurs, it is the obligation of the individual concerned to promptly notify the Insurance office of the new active appointment and to make the necessary arrangements for a switch in health insurance enrolment from after-service health insurance status to that of an active staff member. If that is not done, the staff member will have no insurance. When the active appointment ends, the Insurance Service must again be informed promptly so that the after-service health insurance status can be reactivated.

## V. Conversion privileges

38. A "conversion" privilege is part of the United Nations group contract with Vanbreda. This privilege allows staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits to "convert" their group medical insurance with Vanbreda to an individual short-term health insurance policy. The individual conversion policy is guaranteed-issue. This means that no proof of the subscriber's good health is required; the insurer cannot refuse to insure an eligible subscriber who timely applies for a conversion policy. Application for an individual policy under the conversion privilege must be made within 31 days of termination of coverage under the United

Nations group policy. The availability of this privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of the individual health insurance policy. **The conversion privilege is designed to provide coverage during a period of transition to more permanent health insurance coverage. The Vanbreda conversion privilege grants coverage up to a maximum of 24 months.**

39. Staff members (subscribers) may apply for a policy of individual coverage under the conversion privilege for themselves only or for themselves and their covered eligible dependants. Moreover, eligible dependants may apply on their own behalf in the following circumstances. Children whose eligibility for insurance ceases as the result of reaching the age of 25 are eligible to apply for a health insurance conversion policy provided they are financially dependent on their parent(s), are unmarried and are not full-time employed. A staff member's spouse whose eligibility for insurance ceases as the result of divorce and who is not full-time employed may also apply. The application for an individual conversion policy MUST be submitted within 31 days of termination of coverage under the United Nations group medical programme.

40. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Vanbreda at the following address:

Vanbreda International
Plantin en Moretuslei 299
2140 Antwerp, Belgium
Telephone No.: +32 3 217 5742
Fax No.: +32 3 272 3969
E-mail: gpl@vanbreda.be

## VI. Claims and inquiries

### Basis for claim reimbursement in United States dollars

41. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Reimbursement in United States dollars is based on the United Nations operational rate of exchange in effect on the date that the medical and dental expenses are incurred and, in the case of hospital expenses, on the date that the hospital bill is rendered.

### Mailing addresses

42. Participants must inform their administrative office of any change in their mailing address in order to ensure that identification cards, reimbursements and explanations of benefits are delivered promptly and appropriately.

### Where to address claims and benefit inquiries

43. Although the staff of the Insurance office is available to assist staff members in administrative matters concerning participation in the Vanbreda plan, claims questions should always be taken up on the first instance directly with Vanbreda.

**Claims address and inquiries about claims**

Postal address: Vanbreda International, Postbox 69, B-2140 Antwerp, Belgium
Dedicated telephone number: +32 3 217 6842
Fax number: +32 3 663 2855
Dedicated e-mail address: mcc001@vanbreda.be

**Member service and general inquiries**

Dedicated telephone number: +32 3 217 5742
Fax number: +32 3 272 3969
Dedicated e-mail address: gpl@vanbreda.be

**Vanbreda International Internet web site**

www.vanbreda-international.be

## VII. Annexes

44. Annex I contains a summary of the benefits payable under the Vanbreda plan.

45. Annex II contains details pertaining to hospitalization in the United States.

46. Annex III describes the Vanbreda direct deposit programme.

# Annex I

## Vanbreda insurance benefits summary

1. The Vanbreda Insurance Programme provides for reimbursement of reasonable and customary charges incurred for medical and hospital treatment costs that result from illness, accident or maternity, up to a maximum of $250,000 per insured participant per calendar year. Additionally, expenses related to dental, hearing and vision care are also covered. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also apply, depending on the type of service, as described in the following paragraphs.

2. The programme reimburses only treatment, supplies or other services that are widely and generally accepted as medically necessary and appropriate for the condition being treated, and when such treatment, supplies or other services are prescribed by a licensed, qualified medical professional. Vanbreda International has the fiduciary duty and discretionary authority to determine, on behalf of the United Nations, what constitutes a covered service or plan benefit under the programme.

3. **Medical expenses** are reimbursed under the Basic and Major Medical components. Reimbursement in respect of medical treatment prescribed or rendered by qualified doctors is equal to 80 per cent of the reasonable and customary charges (see para. 20 below for information about reasonable and customary). Services rendered by a licensed paramedical professional or, in case of maternity, by a licensed midwife, can be considered for reimbursement, but only upon the prescription of a licensed, qualified medical professional. The Major Medical component does not apply in the case of dental treatment, outpatient mental health treatment, treatment for substance abuse (alcohol and/or drug), expenses for hearing aids and expenses for optical lenses.

4. **Reimbursement rates**:

(a) Under the Basic Medical component, reimbursement in respect of medical treatment prescribed by qualified doctors is calculated at the rate of 80 per cent of the reasonable and customary charges involved, including doctors' fees;

(b) Under the Major Medical component, 80 per cent of the residual unpaid reasonable and customary charges are paid, subject to a calendar year maximum co-payment of $200 per participant and $600 per family. This calendar year maximum co-payment is sometimes called a "deductible".

This means that the participant pays the 20 per cent residual out-of-pocket charge, up to the calendar year maximum co-payment of $200, or $600 in the case of family coverage. When covered expenses exceed the calendar year maximum co-payment amount, the 80 per cent Basic Component still applies, and the Major Medical component automatically reimburses 80 per cent of the residual 20 per cent for the remainder of that calendar year.

5. **Example: medical expense reimbursement**. The following example illustrates how reimbursement is determined for an individual in respect of Basic and Major Medical coverage:

| | *United States dollars* |
|---|---|
| (a) Basic coverage | |
| Reasonable and customary charges for medical treatment | 3 200 |
| Reimbursement at 80 per cent | 2 560 |
| Residual 20 per cent | 640 |
| (b) Major medical coverage | |
| 20 per cent residual not reimbursed by basic coverage | 640 |
| Less calendar year maximum co-payment | -200 |
| = Basis for major medical coverage | 440 |
| x 80 per cent = Major Medical reimbursement | 352 |
| (c) Total reimbursement (recapitulation of (a) and (b)) | |
| Basic Medical coverage | 2 560 |
| Major Medical coverage | +352 |
| Total insurance reimbursement | 2 912 |
| Participant's total out-of-pocket expense | 288 |
| Total original expense | 3 200 |

6. **Inpatient hospital expenses** are reimbursed at 100 per cent of the reasonable and customary charges when the patient is admitted as an inpatient; that is, when there is at least one overnight stay at the hospital, so that the date of discharge differs from the date of admission. Inpatient hospital services include such items as bed and board, general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. Covered hospital services do not include doctors' fees.

6.1. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care; that is, two or more patients in the same room, except that, under the following circumstances, and subject to the provision of documentation satisfactory to the insurer, private-room care will be reimbursed in full up to the daily limit specified in subparagraph 7 (a) below:

(a) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(b) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(c) When the patient is admitted to a hospital that does not have any semi-private accommodation; that is, it has no standard of accommodation other than private rooms and general wards.

6.2. Europe and North America are defined for this purpose as Europe, including Malta, Cyprus and Turkey (European portion), and Canada and the United States of America.

7. **Reimbursement for hospital accommodation expenses is subject to daily room rate caps.** For 2005, the maximum reimbursement per day for hospital accommodation (room and board) is as follows:

(a) *Europe and North America* — $600 per day;

(b) *Israel* — $700 per day;

(c) *Rest of world* — $330 per day at all locations other than Europe, North America and Israel.

8. **Outpatient hospital expenses** are reimbursed at 80 per cent of the reasonable and customary charges. Outpatient expenses are those rendered in an outpatient, ambulatory or day-surgery setting at a hospital. These outpatient hospital expenses are reimbursed under the Basic Medical and Major Medical programme components.

9. Well-child care/immunizations are covered at 80 per cent of the reasonable and customary fee under the Basic Medical component of the plan, and a further 80 per cent under the Major Medical component, if applicable, in accordance with the following schedule:

(a) Well-child care to the age of 7 years:

- 6 visits per year aged 0 to 1st birthday
- 2 visits per year aged 1 to 2nd birthday
- 1 visit per year aged 2 to 7th birthday

(b) Over the age of 7, 1 visit every 24 months up to the 19th birthday.

10. The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum of $900 per insured participant per calendar year. The cost of dento-facial orthopaedics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years. The Major Medical component does not apply.

11. The cost of outpatient mental health treatment rendered by a psychiatrist is covered, as are the services of a licensed psychoanalyst, a licensed psychologist or a licensed psychiatric social worker. The cost in respect of insured participants is reimbursable at the rate of 80 per cent of the reasonable and customary fee, to a maximum reimbursement of $1,000 per insured person per calendar year. The Major Medical component does not apply.

12. The cost of treatment for substance abuse (alcohol and/or drug) is covered under certain conditions. The coverage includes inpatient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Vanbreda. Such treatment will normally be limited to 30 days in any calendar year. In addition, the plan covers outpatient counselling for the purpose of diagnosis and treatment. The costs of outpatient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counselling of covered family members of the participant undergoing treatment for the substance abuse problem. The Major Medical component does not apply.

13. The cost of radiological treatment is reimbursable at the rate of 80 per cent of the reasonable and customary fee level under the Basic Medical component and a further 80 per cent under the Major Medical component if applicable, provided that the patient has been referred to the specialist by the doctor in attendance.

14. A routine eye examination is covered every 24 months at 80 per cent of the reasonable and customary fee under the Basic Medical component, and a further 80 per cent under the Major Medical component, if applicable.

15. The cost of hearing aids and optical lenses is covered, with the limitations set out below, so long as the staff member or the participating family member has been a participant in the Vanbreda scheme for one year or more:

(a) *Hearing aids*. Reimbursement at 80 per cent (only Basic Medical coverage, no Major Medical coverage), with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear per period of three years; this period starts on the date the first hearing aid is purchased;

(b) *Optical lenses*. Reimbursement at 80 per cent (only Basic Medical coverage, no Major Medical coverage), with a maximum of $60 per lens and a maximum of two lenses per period of two years. This period starts on the date the first lens is purchased. These maxima will also apply to surgical or laser treatment for the correction of refraction.

16. The reasonable and customary charges for two blood tests per year for the human immunodeficiency virus.

17. The reasonable and customary charges for a mammography screening (examination) comprising the following provisions:

(a) Upon recommendation of a physician, a mammogram may be covered at any age for persons having a prior history of breast cancer or whose mother or sister has had a prior history of breast cancer;

(b) A single baseline mammogram will be covered for persons aged from 35 through 39 years;

(c) A mammogram will be covered every two years, or more frequently upon the recommendation of a physician, for persons aged from 40 through 49 years, inclusive;

(d) An annual mammogram will be covered for persons aged 50 and older.

Mammography screenings are covered whether carried out in a medical provider's office, hospital outpatient department, hospital ambulatory surgery department or ambulatory surgery facility, or another facility that is licensed to provide mammography screenings. The screening is covered in accordance with the reimbursement provisions and limitations set out above.

18. The reasonable and customary charges for urological examinations and Prostate Specific Antigen (PSA) screenings are covered as follows:

(a) In asymptomatic males over the age of 40 years, one urological exam and PSA screening is covered every two years. An annual exam and screening is covered after the age of 75 years;

(b) For all other males, including men with a family history of prostate cancer, aged 40 years and over, one urological exam and PSA screening per year is covered.

19. **Exclusions. The insurance programme does not cover:**

(a) Preventive care, including periodic preventive health examinations;

(b) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(c) Insured participants who are mobilized or who volunteer for military service in time of war;

(d) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(e) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(f) Spa cures, rejuvenation cures or cosmetic treatment (cosmetic surgery is covered where it is necessary as the result of an accident for which coverage is provided);

(g) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(h) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded;

(i) In-vitro fertilization;

(j) Frames for glasses;

(k) Expenses which are not deemed to be reasonable and customary.

20. The determination of the reasonable and customary charge for each service is made by Vanbreda, based on the prevailing charges for the service at the place where treatment is rendered, and considering the complexity of the treatment, including related services or supplies. Fees for treatments, supplies or services which are determined by Vanbreda to be excessive compared with prevailing fee levels will be reimbursed up to the reasonable and customary level for the geographical area in which such medical services are received.

21. Members are reminded that claims for reimbursement must be submitted to Vanbreda no later than **two years** from the date on which the medical expenses were incurred. *Claims received by Vanbreda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.*

# Annex II

## Provisions pertaining to hospitalization in the United States of America

1. Participants are free to seek admission to a hospital in the United States of America without providing any notification to Vanbreda. **However, reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate.** Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the reimbursement for other services. Please note that hospital costs vary considerably throughout the United States, and costs may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C. Hospital costs also vary by institution, and may be much higher in certain hospitals.

2. The *$600 limit will not apply* to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States where there is prior authorization by the United Nations Medical Director;

(b) In cases of **bona fide** medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $600. In such cases, to avoid the obligation to meet daily room-rate expenses in excess of $600, specific confirmation that the daily limit does not apply must be obtained from Vanbreda prior to hospital admission.

3. Please note that staff members, former staff members and their eligible dependants who **reside** in the United States are not eligible for coverage under the Vanbreda plan.

# Annex III

## Direct deposit of claims reimbursements into members' bank accounts

1. Members are reminded of the option to have their claims reimbursements deposited directly into their personal bank accounts. Direct deposits can be made only in United States dollars. Election of this option can be made on the claim form which is posted on Vanbreda's dedicated web site for United Nations participants, www.vanbreda-international.be. Use of the claim form available on the Vanbreda web site is recommended since it facilitates the settlement of claims by printing the participant's name and Vanbreda reference number as well as a corresponding bar code on the form. A Vanbreda claim form is also posted on the United Nations insurance Internet web site, www.un.org/insurance, but the form on the United Nations web site does not contain the unique reference number or bar code.

2. Enter the following bank information on the Vanbreda claim form. Your bank can provide you the information in (d) and (e)

(a) Bank name and full address;

(b) Bank account number;

(c) Account holder's name;

(d) IBAN code (International Bank Accounts Number) for cross-border payments within the European Union (if IBAN is not available, provide the corresponding local bank code, e.g., ABI/CAB for Italy, Bankleitzahl for Germany, Sorting Code for U.K., etc.);

(e) Bank identification code: either the BIC/SWIFT code, or the ABA code in the United States.

3. Please note that the direct deposit option is not available for deposits into bank accounts in the following countries: Cuba, Iran (Islamic Republic of), Iraq, the Democratic People's Republic of Korea, Liberia, Montenegro, Myanmar, Nauru, Serbia, the Sudan and Zimbabwe.